Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Gordon, a prisoner at HMP Birmingham, on 30 March 2023

A report by the Prisons and Probation Ombudsman

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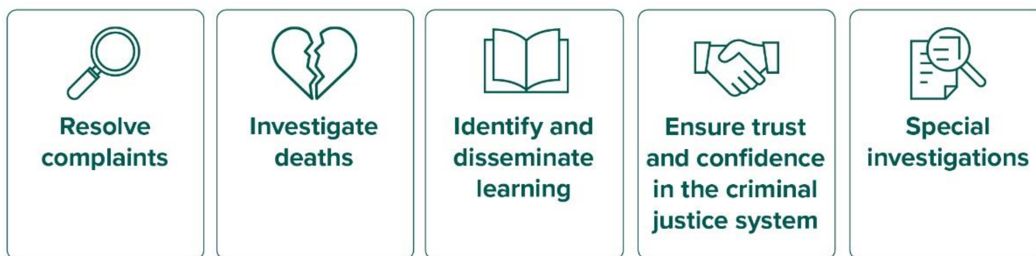
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

2. If my office is to best assist HM Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Anthony Gordon died in hospital on 30 March 2023, of multiple organ failure caused by sepsis (a serious infection), while a prisoner at HMP Birmingham. He was 50 years old. Mr Gordon also had end stage renal failure which contributed to but did not cause his death. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Gordon received at Birmingham was of a very good standard and, in relation to renal dialysis treatment, was in excess of what he could have expected to receive in the community.

5. The clinical reviewer concluded that the healthcare team at Birmingham should be congratulated for the care they provided to Mr Gordon and that they clearly went above and beyond to provide him with his dialysis and treatment for his other complex care needs.

6. The clinical reviewer made three recommendations not directly related to Mr Gordon's death which the Head of Healthcare will need to address.

7. On 8 March and 28 March, when Mr Gordon was sent to hospital by ambulance, prison mangers authorised that he be restrained despite his obvious failing health. This is an issue that we have raised in previous investigations at Birmingham.

Recommendation

- The Operational Security Group Director for HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient admissions and outpatient appointments), including at HMP Birmingham, and discuss the findings with the Ombudsman.

The Investigation Process

8. On 30 March 2023, the PPO was informed of Mr Gordon’s death.

9. NHS England commissioned an independent clinical reviewer to review Mr Gordon’s clinical care at Birmingham.

10. The PPO investigator investigated the non-clinical issues relating to Mr Gordon’s care.

11. The investigator and clinical reviewer jointly interviewed two members of staff by video on 17 May.

12. The PPO family liaison officer wrote to Mr Gordon’s sister to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

13. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Previous deaths at HMP Birmingham

14. In the three years before Mr Gordon’s death, there were 11 deaths from natural causes at Birmingham, two of which were related to COVID-19, three self-inflicted deaths and a homicide.

15. We made recommendations relating to the inappropriate use of restraints after the deaths of prisoners in March 2021, June 2021, and January 2022. The prison accepted the recommendations, and the Governor wrote to prison managers advising them to take into account the health of the prisoner at the time of the escort.

Key Events

16. On 18 December 2019, Mr Anthony Gordon was sentenced to 17 years in prison for sex offences and was sent to HMP Birmingham.

17. Mr Gordon had chronic kidney disease and required kidney dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly) three times a week. He also had hypertensive renal disease with kidney failure (damage to the kidney caused by chronic high blood pressure), and a failed kidney transplant in 2007. Mr Gordon's chronic kidney disease was further complicated by other long term health conditions.

18. In the community, Mr Gordon received dialysis treatment at the University Hospital. When he was sent to Birmingham, he was transferred to the Queen Elizabeth Hospital for this treatment.

19. The Head of Healthcare purchased two dialysis machines for use at Birmingham to reduce the number of escorts to hospital. In July 2021, Mr Gordon's dialysis started at Birmingham, which was delivered by NHS staff from the Queen Elizabeth Hospital who came to the prison three times a week.

20. On 21 October 2022, a nurse received a telephone call from hospital staff carrying out Mr Gordon's dialysis treatment, who told her that he needed to go to hospital because he had a chest infection. He was admitted to hospital. Mr Gordon had previously had a pulmonary embolism (a blockage in the pulmonary arteries, blood vessels that send blood to the lungs) and had many lung conditions.

21. On 9 November, hospital staff said that Mr Gordon's health was deteriorating. Mr Gordon received intravenous antibiotics and his health improved. On 13 December, Mr Gordon returned to Birmingham.

22. On 8 March 2023, a nurse found Mr Gordon unwell and radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). The nurse noted that Mr Gordon's National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration) was 10 (a score above 7 requires an emergency response) and sent him to hospital by ambulance. When he went to hospital, Mr Gordon was restrained with an escort chain. Mr Gordon was admitted to the Intensive Care Unit. In hospital, prison staff removed Mr Gordon's restraints for hospital staff to carry out tests and treatment.

23. On 17 March, the Head of Reducing Reoffending told healthcare staff that hospital staff had stopped all treatment for Mr Gordon who had low blood pressure, and they estimated that he had 24-hours to live. On 19 March, Mr Gordon's condition improved, and he was transferred to a normal ward.

24. On 20 March, a nurse noted that Mr Gordon was now categorised as receiving palliative care under the hospital end-of-life pathway, which would continue if he returned to Birmingham. On 22 March, the Head of Drug Strategy reviewed the level of restraint and authorised that Mr Gordon be restrained. Prison staff reapplied an escort chain. On 23 March, Mr Gordon returned to Birmingham.

25. On 28 March, a nurse noted that Mr Gordon was on the floor of his cell, having fallen while getting to his wheelchair. She noted that his blood oxygen saturation was low and gave him oxygen. Another nurse radioed a medical emergency code blue. A GP at Birmingham discussed Mr Gordon's observations with a nurse and because his blood oxygen saturation improved, stood the ambulance down. However, at the same time hospital staff telephoned healthcare staff and told them that Mr Gordon's blood tests showed that he had low calcium levels and possible sepsis. The nurse sent Mr Gordon to hospital by ambulance.

26. Before Mr Gordon left for hospital, prison staff completed an escort risk assessment. The nurse completed the medical section and did not answer the medical objection to the use of restraints section. However, she noted that Mr Gordon used a wheelchair and had to go to hospital because he had deranged blood tests which showed that he could have sepsis. A Custodial Manager (CM) completed the analysis of Mr Gordon's risk and noted that, on 23 January, he had a very bad attitude with staff, and, on 6 March, Mr Gordon was awkward and impatient with staff. He noted that Mr Gordon was a low risk of escape and a medium risk to staff and to the public. He recommended that two officers escort Mr Gordon and that he be restrained with a single cuff. The Head of Security authorised that Mr Gordon be restrained with an escort chain and noted that his mobility was reduced, that he used a wheelchair but was able to walk. She noted that he previously demonstrated poor behaviour and attitude towards operational and clinical staff. When he went to hospital, Mr Gordon was therefore restrained.

27. At 6.50pm on 29 March, the Head of Safety and Equalities reviewed the level of restraint and noted that Mr Gordon was nearing the end of his life. He authorised that the restraint be removed. Prison staff removed the restraint.

28. On 30 March, Mr Gordon died in hospital.

Post-mortem report

29. There was no post mortem examination. A hospital consultant recorded that Mr Gordon died from multi organ failure caused by sepsis (a severe infection). He also had end stage renal (kidney) disease which contributed to but did not cause his death.

Inquest

30. The inquest, held on 8 January 2024, concluded that Mr Gordon died from natural causes.

Findings

Clinical care

31. The clinical reviewer found that the clinical care that Mr Gordon received at Birmingham was of a very good standard and that his dialysis treatment was in excess of what he could have expected to receive in the community.

32. The clinical reviewer found that Mr Gordon's chronic renal failure was managed very well by the healthcare team. Healthcare staff worked hard to ensure that Mr Gordon received dialysis treatment. There was good communication between healthcare and hospital staff managing the dialysis.

33. The clinical reviewer made three recommendations not directly related to Mr Gordon's death which the Head of healthcare will need to address.

Good practice

34. The clinical reviewer concluded that the healthcare team at Birmingham should be congratulated for the care they provided to Mr Gordon. She found that they clearly went above and beyond to provide him with his dialysis and treatment for his other complex care needs.

Restraints, security and escorts

35. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

36. On both 8 March 2023 and 23 March 2023, Mr Gordon was sent to hospital when seriously ill with handcuffs used to restrain him. On both occasions, he was admitted in an emergency when seriously unwell. As well as this, Mr Gordon used a wheelchair and was in generally poor health. We are not satisfied that it was appropriate to restrain Mr Gordon in these circumstances.

37. In the three years before Mr Gordon died, we made three separate recommendations regarding the use of restraints on prisoners in poor health. In their action plan following the most recent of these investigations, HM Prison and Probation Service told us that the Governor had reinforced with prison managers the need to record how a decision regarding the use of restraints had been reached. The Governor said that operational managers who fail to consider the prisoners' health and actual risk, and do not evidence a defensible restraints decision, will be subject to local investigation.

38. Despite these action points and our repeated recommendations, we have again found that a prisoner was inappropriately restrained. We make the following recommendation:

The Operational Security Group Director for HMPPS should monitor compliance with policy on the use of restraints during hospital escorts (for inpatient admissions and outpatient appointments), including at HMP Birmingham, and discuss the findings with the Ombudsman.

Adrian Usher
Prisons and Probation Ombudsman **January 2024**

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